First Health Services Corporation
A Coventry Health Care Company

Provider Service Center Authorization

Please review and check the block(s) which pertain to you:

☐ **SERVICE CENTER AUTHORIZATION:**

I certify that I have authorized the following service center(s) to submit electronic transactions to the Department of Medical Assistance Services until such time as I notify First Health Services otherwise:

NAME OF SERVICE CENTER PREPARING ELECTRONIC TRANSMISSION

If Adding a New Service Center or a New Transaction:	
SERVICE CENTER NUMBER:	**BEGIN DATE:**
ELECTRONIC TRANSACTION TYPES SUBMITTED:	
☐ Eligibility Req/Resp (270/271)	☐ Claims Status Req/Resp (276/277)
☐ Prior Authorization Req/Resp (278/278)	☐ Dental (837 D)
☐ Institutional (837 I)	☐ Professional (837 P)
☐ Pharmacy (NCPDP – batch)	
If Terminating a Service Center or a Transaction:	
SERVICE CENTER NUMBER:	**END DATE:**
TERMINATED ELECTRONIC TRANSACTION TYPES:	
☐ Eligibility Req/Resp (270/271)	☐ Claims Status Req/Resp (276/277)
☐ Prior Authorization Req/Resp (278/278)	☐ Remittance Advice (835)
☐ Dental (837 D)	☐ Institutional (837 I)
☐ Professional (837 P)	☐ Pharmacy (NCPDP – batch)

Please select A or B for an 835 Electronic Remittance Request:

☐ **A** I desire to have Service Center _____ receive my electronic remittances (835) and I understand that I will continue to receive paper remittances only for 30 days after the electronic remittances start. **Refer to Terms and Conditions on Page 2, Item A.**

☐ **B** I desire to have Service Center _____ receive my electronic remittances (835) and I would like my paper remittances to continue for the period selected below. **Refer to Terms and Conditions on Page 2, Item B.**

Please extend my remittance for:

☐ 60 Days ☐ 90 Days ☐ 120 Days

Fax to: 1-804-273-6797, or
Mail Original to:
First Health Services Corporation
Electronic Media Claims Coordinator
Virginia Medicaid Operations
4300 Cox Road
Glen Allen, VA 23060

PROVIDER SERVICE CENTER AUTHORIZATION:

I understand that I am responsible for the information presented on these invoices and that the information is true, accurate, and complete. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws. This agreement will become effective when executed by both parties and may be amended only in writing, similarly executed.

PROVIDER NAME		PROVIDER NUMBER
SIGNATURE	DATE	TELEPHONE NUMBER

TERMS AND CONDITIONS:

A. Electronic Remittance Request (835) and Paper Remittances for 30 Days after Production Approval.

I certify that I have authorized the Service Center identified on Page 1 to receive and process my electronic remittances. Although I can have multiple service centers submitting claims for me, I understand that only one service center can accept and process my electronic remittances and that service center must have prior approval from First Health Services to receive electronic remittances. I am also aware that 30 days after I start getting electronic remittances, all paper remittances will cease.

B. Electronic Remittance Request (835) and Paper Remittances Extended for 60 Days, 90 Days, or 120 Days after Production Approval.

I certify that I have authorized the Service Center identified on Page 1 to receive and process my electronic remittances. Although I can have multiple service centers submitting claims for me, I understand that only one service center can accept and process my electronic remittances and that service center must have prior approval from First Health Services to receive electronic remittances. I am also aware that after I start getting electronic remittances, all paper remittances will cease after the delay I selected on Page 1.

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